Related Medlearn Matters Article #: MM4219

Date Posted: January 10, 2006

Related CR #: 4219

2006 Oncology Demonstration Project

Key Words

MM4219, CR4219, R36DEMO, oncology, demonstration

Provider Types Affected

Hematologists and oncologists who bill Medicare for the care of cancer patients

Key Points

- The effective date of the instruction is January 1, 2006.
- The implementation date is January 17, 2006.
- The 2006 Oncology Demonstration Project's purpose is to identify and assess, in office-based oncology practices, certain oncology services that positively affect outcomes in the Medicare population.
- This project replaces the 2005 chemotherapy demonstration project, and substantially changes the reporting emphasis.
    - In the 2006 project, your reporting will no longer be specific to chemotherapy administration services, but, instead, will be associated with physician evaluation and management (E & M) visits for established patients with cancer.
    - The project builds on the use of G-codes to gather more specific information about patients with particular types of cancer, including information about the primary focus of the visit and the spectrum of care that you provide.
    - It will emphasize practice guidelines as the source for standards of care.
    - Calendar year 2005 G-codes (G0921 to G0932), specific to the assessment of patient symptoms, have been eliminated, effective December 31, 2005; while new G-codes have been adopted.

G-Codes Address Three Reporting Categories

- The Centers for Medicare & Medicaid Services (CMS) has established 81 new G-codes that address three reporting categories:

- The primary focus of the evaluation and management visit;
- Whether current management adheres to clinical guidelines; and
- The current disease state.

Diagnostic Categories

- Office-based hematologists and oncologists can participate in this demonstration when they provide an E & M service of level 2, 3, 4, or 5 to an established patient (American Medical Association's Current Procedural Terminology (CPT) codes 99212, 99213, 99214 and 99215) with a primary diagnosis of cancer belonging to one of the following 13 major diagnostic categories:
  - Head and neck cancer (140.0 –149.9, 161.0-161.9)
  - Esophageal cancer (150.0-150.9)
  - Gastric cancer (151.0-151.9)
  - Colon cancer (153.0-153.9)
  - Rectal cancer (154.0, 154.1)
  - Pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9)
  - Lung cancer (both non-small cell and small cell) (162.2-162.9)
  - Female breast cancer (invasive) (174.0-174.9)
  - Ovarian cancer (183.0)
  - Prostate cancer (185)
  - Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)
  - Multiple myeloma (203.00, 203.01)
  - Chronic myelogenous leukemia (205.10, 205.11)

To Qualify for the Payment

- To qualify for the payment associated with this demonstration payment, you must submit one G-code from each of the three reporting categories mentioned above when you bill for an E & M of level 2, 3, 4, or 5 for established patients.
- Practices reporting data on all three categories will qualify for an additional oncology demonstration payment of $23 in addition to the E & M visit.

Important Details

- Participation is voluntary and is accomplished by the physician filing a claim for services (i.e., a level 2, 3, 4, or 5 established office visit with three separate G-codes, one from each reporting category) with the Medicare carrier.
- The physician specialties that qualify for this demonstration are hematology (specialty code 82), medical oncology (specialty code 90), and hematology/oncology (specialty 83).

- Medicare carriers will deny claims for this demonstration submitted by other than a qualifying specialty.
  - Midlevel practitioners (such as nurse practitioners or others who may bill independently for Medicare services) are not eligible to participate.
  - Such claims will be denied with remittance advice code N95 and claim adjustment reason code 185.
- E & M services that are furnished for patients with cancer types as the principal diagnosis, other than those listed in the Diagnostic Categories above, will not be included in the demonstration.
- Claims reported with demonstration G-codes not related to the 13 specific cancer types, those G-codes will be denied.
- The project applies only to Medicare beneficiaries who are not enrolled in a Medicare Advantage plan, and is effective only for services provided within CY 2006.
- Any oncology demonstration G-codes that are billed for dates of service not within CY 2006 will be returned using Remittance Advice reason code B18 and remark code N56 and Medicare Summary Notice (MSN) message 16.13.
- If chemotherapy is provided on the same day as the E & M visit, it is only the latter that is linked to the demonstration project.
  - In this case modifier 25 should be attached to the E & M service.
  - This denotes performance of a significant, separately identifiable evaluation and management service on the same day of a procedure.
  - Appropriate documentation should be included in the patient's record to support the level of the E & M service billed.
- Physicians must bill a code from each of the three reporting categories mentioned above.
  - If one or more of the demonstration codes (but not one from all three categories) is billed on a single claim, carriers will return/reject the claim as not able to process and use Remittance Advice reason code 16 and remark code MA 130.
  - Conversely, if more than one G-code from the same category for the same date of service on the same claim (for instance, you submit a claim for more than two G-codes from the category of "primary focus of the visit") is billed, carriers will also reject the claim as not able to process and use remittance advice reason code 125 and remittance advice remark code MA130.
  - Some Medicare carriers may choose to manually split the claim and only return the "not able to process" portion, but CMS will not require carriers to do this.
- Claims must be assigned.
  - If a participating provider submits a non-assigned claim for the oncology demonstration G codes, carriers will process the claim as assigned and generate Remittance Advice remark code MA09.
  - If a nonparticipating provider submits a non-assigned claim for the G-codes and related E & M service, carriers will process the claim for coverage and payment of those services that do not

require assignment (e.g., the evaluation and management service) and deny the G-codes using Remittance Advice reason code 111, remark code N149, and MSN message 16.6.

  - Providers may resubmit G-codes that were denied for not accepting assignment and the G-codes will be approved if the related E & M codes were approved.
  - However, if there is no approved E & M code for the same service date and place of service as the G-codes on the claim or in the history, carriers will deny the G-codes using Remittance Advice reason code 107 and MSM code 16.26.
- The place of service reported for codes must be "office" (place of service code 11). If the place of service reported is other than "office," carriers will return/reject the claim as not able to process using Remittance Advice reason code 5 and MSN code 16.2.
- Carriers will establish the following payment allowances and determine payment based on the lesser of 80 percent of the actual charge or on the allowance by code:
  - G9050 to G9055 - $7.67
  - G9056 to G9062 - $7.67
  - G9063 to G9130 - $7.66
  - These amounts apply in all localities, and the usual Part B coinsurance and deductible apply.
- During the demonstration, the oncology G-codes will bypass SNF consolidated billing for beneficiaries in a Part A stay.
- The new 2006 oncology G codes and their descriptor can be viewed on pages 6 – 12 of the Medlearn Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf on the CMS web site.

Important Links

http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4219.pdf

http://www.cms.hhs.gov/transmittals/downloads/R36DEMO.pdf

http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf